Care Expense Statement

Section 1: General Information *(To be completed by the facility administrator or care provider. Please print.)*

VA claim number: _____

Veteran's name: _____

Patient's name: _____

Check the box which describes the patient's care status:

*☐ In-Home Care

☐ Nursing Home Care

☐ Other Care Facility *(Foster Home, Adult Day Care, Rest Home, Group Home, or Assisted Living)*

*Name of facility or care provider: _____

*Phone number of facility or care provider: _____

*Address of facility or care provider:

***Date** entered facility or **in-home care began**: _____

***Will the patient need this care indefinitely?** ☐ Yes ☐ No

If *No*, when will the care end? _____

***Total monthly charge for the patient:** $ _____ per month

***Total Paid to provider by claimant in year _____.**

$ _____

***Has the patient applied for Medicaid?** ☐ Yes ☐ No

***When did patient apply for Medicaid?** _____.

***Is part of the patient's cost covered by Medicaid, Medicare, or insurance?** ☐ Yes ☐ No

If *Yes*, please answer the following:

What is the source of the payment? _____

What is the monthly amount covered by this source? $ _____ per month

When did coverage begin? _____

***What monthly amount does the veteran or patient pay from his/her own funds which is not reimbursed by one of the sources listed above?** *(If the patient is receiving Medicaid, what amount does Medicaid take from the patient?)* $ _____ per month

If the patient is receiving Medicaid, attach a copy of the SDS-512 Medicaid Form.

Continue on page 2.
Be sure to sign and date in Section 6. → → → →

Section 2: In-Home Care Information *(To be completed by the care provider only if the patient is being provided in-home care.)*

*** Do you provide any medical or nursing services for the patient?**
(i.e. administering medication; physical or mental therapy; assisting with personal hygiene, dressing, bathing; etc.) ☐ Yes ☐ No

***Describe the services you provide:** _____

_____

_____

Are you a licensed health professional?(registered nurse, licensed vocational nurse, or licensed practical nurse)* ☐ Yes ☐ No
If *Yes*, provide your license number: _____

Which of the following services do you provide?

☐ Assistance with bathing and /or showering

☐ Assistance with dressing

☐ Assistance with eating and/or drinking (not including meal preparations)

☐ Assistance with mobility (i.e. getting in or out of bed, a chair, etc)

☐ Assistance with personal hygiene needs (i.e. using the toilet, brushing teeth, etc.)

If you charge by the hour, please list your hourly rate and weekly hours worked:

Weekly Hours: _____ $ _____ per hour

****See Section 5 for documentation requirements for in-home care**

Section 3: Nursing Home Information *(To be completed by the facility administrator only if the patient is in a nursing home.)*

Is your facility licensed by the State? ☐ Yes ☐ No

Is your facility Medicaid approved? ☐ Yes ☐ No

Is the patient in your nursing home because of a physical or mental disability? ☐ Yes ☐ No

Do you provide either skilled or intermediate level nursing care to the patient? ☐ Yes ☐ No

What was the admitting diagnosis? _____

_____

Section 4: Other Care Facility Information

(To be completed by the facility administrator only if the patient is in a foster home, adult day care, rest home, group home or assisted living.)

Indicate type of facility: ☐ Foster Home ☐ Adult Day Care ☐ Rest Home ☐ Group Home ☐ Assisted Living ☐ Other: _____

Which of the following services do you provide?

☐ Assistance with bathing and /or showering

☐ Assistance with dressing

☐ Assistance with eating and/or drinking (not including meal preparations)

☐ Assistance with mobility (i.e. getting in or out of bed, a chair, etc)

☐ Assistance with personal hygiene needs (i.e. using the toilet, brushing teeth, etc.)

Do you provide any additional medical or nursing services for the patient? ☐ Yes ☐ No

Describe the services you provide: _____

If a 3rd party provides the services listed above, please list their name, address, and phone number:

Important: Please have the 3rd party complete the in-home care section above and sign and date the last section.

If the patient receives medical or nursing services, are the services provided or supervised by a licensed health professional? *(registered nurse, licensed vocational nurse, or licensed practical nurse)* ☐ Yes ☐ No

We must have the monthly charge broken down into the following two categories:

1. Base Rate *(includes room, meals, laundry, housekeeping)*: $_____ per month
2. Medical and Nursing Services: $_____ per month

Section 5: In-Home Care Information *(To be completed by the care provider only if the patient is being provided in-home care.)*

To allow medical expenses for in-home caregivers, VA regulations require you to submit specific documentation of expenses from all of your caregivers.

What We Need:

In order to allow fees for the in-home attendants, receipts or other documentation is required. Documentation includes:

- A receipt bill
- Statement on the provider's letterhead
- Computer summary
- Ledger, or
- Bank statement

The Evidence Submitted Must Include

- The amount paid
- The date payment was made
- The purpose of the payment (the nature of the product or service provided)
- The name of the person to or for whom the product of service was provided
- Identification of the provider to whom payment was made

Note: A family member may be considered an in-home attendant only if he/she is actually ***being paid***. Documentation must be submitted.

Section 6: Signatures *(To be completed by the facility administrator/care provider and the veteran/beneficiary.)*

I certify that the above statements are true and correct to the best of my knowledge and belief.

_____ _____

Signature of facility administrator or **care provider** Date

I certify that above statements are true and correct to the best of my knowledge and belief.

_____ _____

Signature of 3rd party contractor (if applicable) Date

I certify that the above statements are true and correct to the best of my knowledge and belief. I am paying

$ ____ per month for my care from my own funds.

_____ _____

Signature of veteran or beneficiary Date